County Medical Services Program

2003
Physician Handbook

Physician Handbook

Section I

CMS Program Overview

The San Diego County Medical Services (CMS) Program is a County funded, safety net program that provides physical health services to eligible medically indigent adults. Although the CMS Program reimburses specialty and ancillary providers at interim Medi-Cal rates, it differs from the Medi-Cal entitlement program. Services are limited to the Program Medical criteria and there are no co-payments. Medical care is provided to the CMS population only for acute illness and chronic conditions, which, if left untreated, would result in death or significant disability.

AmeriChoice

AmeriChoice serves as the CMS Program Administrative Services Organization (ASO) and administers day-to-day activities including case management and coordination of care, utilization review and prior authorization, patient and provider relations, claims payment, financial management and program development and analysis.

Questions and concerns about the operations of this program should be directed to:

AmeriChoice
CMS Program Provider Relations
PO Box 939016
San Diego, CA 92193
(858) 492-4422

Section II

Eligibility

Overview

To be eligible for CMS services, patient must:

- Have an immediate or long term medical need
- Be a US citizen or eligible alien
- Be a resident of San Diego County
- Be 21 through 64 years old
- Not be linked to Medi-Cal (aged, blind, CalWORKS or disabled)
- Be within CMS income limits or receive General Relief
- Be within CMS resource limits

Financial Criteria

Financial eligibility criteria for the CMS Program are based on resources and income. Resources include, but are not limited to: cash, funds in checking and savings accounts, and real property other than the patient's primary home.

The CMS Program sets a limit on monthly income based on family size after certain deductions. The chart below shows resource and income limits for the CMS Program.

	Resource Limits	Income Limits
Family Size	1989	(as of 7/1/01)
1	$2,000	802
2	3,000	1,084
3	3,150	1,366
4	3,300	1,648
5	3,450	1,930
6	3,600	2,212
7	3,750	2,493
8	3,900	2,775
9	4,050	3,058
10	4,200	3,339
Over 10	4,200	Additional $282.00/person

Citizenship/Eligible Alien Status

Patients must have U.S. citizenship or eligible alien status and must provide proof of status before certification.

Residency

Patients must live in a primary residence located in San Diego County and must provide proof of residence before certification. A fixed address is not required. Patients living on the streets or in a vehicle can be county residents. Patients "visiting" from other counties, states, or countries are not eligible.

Eligibility Appointments

Human Services Specialists (HSS) are located in select Community Health Centers and Public Health Centers and local hospitals. HSSs are County employees responsible for determining CMS eligibility. Eligibility appointments with HSSs at the Community Health Centers and Public Health Centers are scheduled by calling (800) 587-8118. Eligibility appointments with HSSs at the hospitals are scheduled by hospital staff or the Hospital Outstation Services (HOS) HSS.

Standard Eligibility

Patients apply for standard eligibility by completing an application and providing verifications to an HSS. The HSS reviews the application and verifications, and makes the decision to approve or deny. The HSS issues the decision in a notice of action to the patient. The HSS provides a CMS ID card and Patient Handbook to approved patients. Initially, patients are approved for a period of 1 to 6 months. Patients receiving General Relief do not complete an application or submit verifications. After verifying the patient's identity and receipt of General Relief, the HSS gives the patient a CMS ID card and a Patient Handbook. Upon renewal, patients with asthma, diabetes and/or hypertension may be approved eligibility for up to twelve (12) months.

Temporary Eligibility

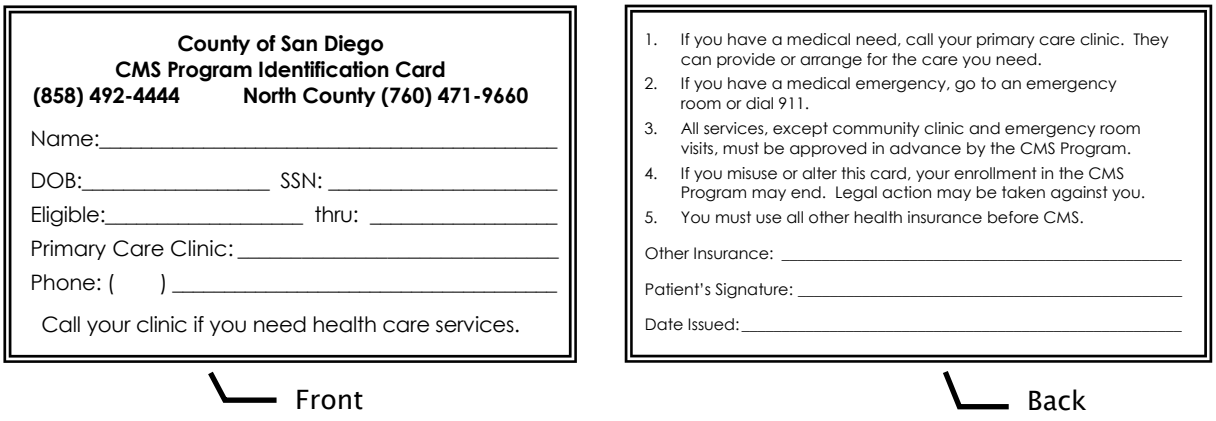
- Emergency Room Application: Patients can apply for coverage for a single emergency room visit by completing an Emergency Room application at a contracting hospital
- Urgent Primary Care Application: Patients can apply for short-term eligibility (20 days) at some community health centers by completing an Urgent Primary Care application

Immediate Care

When a non-certified patient requires immediate medical care that the clinic cannot provide, the patient should call the CMS Patient Information Line (858) 492-4444 or from North County (760) 471-9660. The Administrative Services Organization (ASO) will evaluate the patient's medical need and if all CMS criteria are met, the ASO will contact the County Health Care Access Division (HCAD) to schedule an urgent eligibility appointment. Following notification of approved eligibility, the ASO will arrange and authorize appropriate care.

CMS Identification Card

CMS patients with standard eligibility receive a CMS Identification Card and a Notice of Action (NOA). The ID card and NOA are proof of eligibility; however, they do not authorize services. An example of the CMS Card is shown below:



Front Back

All non-emergent services must be prior authorized. Authorization of services cannot be generated until the patient's eligibility is entered into the CMS Program Information System.

Fraud Referral

When you suspect that a patient is not eligible for CMS, you should call the Patient/Provider Coordinator at **(858) 492-4422**. You should be able to give the patient's name, address, birth date, and social security number and the reason you suspect fraud. You can remain anonymous.

Section III

Physical Health Services

The CMS Program covers medical services for serious health problems, which, if untreated, could be life threatening or significantly disabling. ASO medical staff is responsible for determining if a patient's medical condition meets the County's medical program criteria.

Covered Services

Services covered by the CMS program that **do not** require prior authorization:

- Evaluation by a primary care provider
- Follow-up care by a primary care provider for serious or chronic health conditions
- Consult with a specialty physician when ordered by the primary care provider
- Emergency room care
- Emergency hospital admissions
- Emergency medical transportation
- Emergency dental care
- Formulary medications

Services covered **only when prior authorized** by the CMS program:

- Care by a specialist
- Scheduled hospital admissions
- Surgical and diagnostic procedures
- Limited rehabilitation, medical equipment and home health services
- Non-emergency medical transportation
- Optometry exams and supplies
- Non-formulary prescription medications

Not Covered Services

The following services/diagnoses are **NEVER** covered:

- Pregnancy and all services during a pregnancy
- Pediatrics
- Family Planning
- Infertility services
- Sterilization procedures
- Mental Health services
- Drug and Alcohol Treatment
- HIV+ (early intervention) care by primary care
- Organ and bone transplants and all related services
- Bone marrow transplants
- Experimental Procedures
- Cosmetic Procedures in the absence of trauma or significant pathology
- Non-emergency dental and vision care
- Routine or work examinations
- Completion of medical certificates
- Counseling for lifestyle problems
- Orthodontia
- Non-prescription medications
- Emergency room visits for after care, follow-up, and to obtain prescriptions

Section IV

Prior Authorizations and Physician Responsibilities

The CMS Program reimburses providers for services provided when the patient has been certified for CMS AND the services have been **prior authorized**. The physician's office is responsible for:

- Verifying that the patient is certified for the CMS Program
- Verifying that non-emergent services to be provided to the patient have been prior authorized by the CMS Program
- Providing the ASO with sufficient documentation to determine the severity of the patient's condition
- Submitting a plan of treatment
- Assuring prior-authorization for continued treatment and/or referrals
- Submitting claims in the format and time frame required by the CMS Program

Section V

Medical Management

Medical Criteria

Medical criteria are used to determine whether or not the CMS Program will cover a service or treatment. The CMS Program will provide coverage for medical care for an eligible patient whose health condition or symptoms meet the following general criteria:

- Life-threatening
  - Major trauma, myocardial infarctions, malignant lesions or tumors, cerebral vascular accidents, etc.
- Acute (conditions that could lead to medical complications or disability)
  - Benign tumors, fractures, gallbladder and ulcer disease, and infectious diseases (bronchitis, strep throat, urinary tract infection, etc.)
- Chronic (conditions that are progressive and require ongoing medical and/or pharmaceutical management)
  - Diabetes, hypertension, asthma, rheumatoid arthritis, etc.

An evaluation by a primary care practitioner, conducted to determine the nature and severity of a condition and to order treatment, is always covered by the CMS Program.

The CMS Medical Director can deny coverage if the Program's medical criteria is not met. The practitioner or the patient has the right to appeal any CMS Program decision that denies a physical health service.

Limited Services

Preventive Care

Patients who are receiving primary care and are diagnosed with long-term, chronic conditions are eligible to receive selected preventive services. Services include:

- Annual ophthalmology and podiatry evaluation for diabetics
- Cholesterol lowering agents for patients diagnosed with diabetes or coronary artery disease
- Cancer screening

Self-Limiting and Minor Conditions

A visit to a primary care practitioner to evaluate the patient's presenting symptom(s) is always a covered service. However, claims submitted with the diagnoses listed below are subject to review prior to approval and may be denied when repetitively submitted as the sole diagnosis.

- Minor (conditions that can be treated with over the counter products)
  - Head lice, first degree sunburn, mild contact dermatitis
- Self-limiting (conditions requiring no medical treatment)
  - Flu, colds

The following table lists the ICD-9 codes that are subject to review:

	ICD-9 Code
Hypercholesteremia	272-272.9
Obesity	278.0
Refractive disorders	367-367.9
Low vision	369-369.9
Acute nasopharyngitis	460
Dental disorders (Repeat services covered when the provider is not a dentist)	521-529.8
Menopausal disorders (except 627.1 – post menopausal bleeding)	627-629
Corns and callosites	700
Keloid scar	701.4
Scar conditions and fibrosis of the skin	709.2
Diseases of the hair	704-704.9
Toxic effects of alcohol	980-980.09
Conditions influencing health status	V40-V49

Stable Long-Standing and/or Congenital Conditions

When a condition is not acute or there is no change in the status of the condition, CMS will cover services provided by a primary care practitioner as needed. These diagnoses are not, however, generally eligible for referral to a specialist. Specialty care may be approved on a case-by-case basis when there is concomitant pathology. Examples are:

- Perforated ear drum without history of recent or recurrent infection
- Cleft lip/cleft palate
- Allergies
- Arteriolsclerotic heart disease
- Myositis, myalgia
- Fibromyalgia, chronic fatigue
- Deviated septum, nasal fractures more than 6 months
- Chronic back or joint pain
- Implanting and removal (unless imbedded) of IUD devices

Ancillary Health Services and Supplies

Generally, ancillary health services and supplies are covered when appropriate for the health condition. Examples of coverage limitations for specific services are:

- Home health services requested only for suture removal
  - Patient's physical condition must render them "home-bound"
- Mammograms
  - Refer women 40 years and older to Breast Cancer Early Detection Program (BCEDP)
- Non-formulary pharmaceutical products
  - Reviewed for the most efficacious and cost effective product
- Custom orthotics are rarely approved
  - Over-the-counter products are preferred
- Dentures - full mouth or anterior stay plate
  - Employment potential and/or long term risk to the patient's health status are primary factors for approval

- Optometry services – eye exams and glasses
  - Best visual acuity (with current prescription) is 20/50 or worse
  - Patient must have a chronic health condition that requires ongoing treatment or monitoring by the primary care practitioner
  - Enrolled for a minimum of 6 months and has received medical attention at least three (3) times

Second Opinion

CMS may authorize a request for a second opinion from the patient or practitioner. CMS also suggests a second opinion when any one of the following circumstances are present:

- A more cost-effective treatment option is available
- Practitioner or patient disagrees with the diagnosis and/or the plan of treatment recommended
- Practitioner or patient is seeking an alternate treatment option that may improve the outcome (i.e., cancer)

Case Management

The physician may request assistance or case management for the patient if appropriate and beneficial by calling AmeriChoice, ASO at (858) 495-1300.

Section VI

Referrals

The County Medical Services Program maintains a network of Community Health Clinics that serve as "medical homes" to CMS patients, which provide integrated, basic primary care services. In the event the CMS patient requires specialty medical treatment the primary care physician will authorize a CMS Supplemental Primary Care Authorization (CMS-20) form found in Attachment A or CMS Request for Referral Services (CMS-19) form found in Attachment B to a CMS specialist (see process listed in the sections below).

Consultations

A consultation is a one-time visit to a specialist physician to assist the primary care practitioner in preparing an individual treatment plan for a CMS patient.

- Clinic completes the Supplemental Primary Care Authorization form identifying the patient, the patient's dates of eligibility, the reason for the consultation, the services authorized, the name of the primary care practitioner and the "valid to" date
- A brief history and any pertinent test results should accompany the Supplemental Primary Care Authorization form
- The form will indicate the one visit and any additional tests or minor procedures that are authorized
- A copy of this form must be included when billing for services, or the claim must identify the referring practitioner and primary care clinic
- Please send your medical findings back to the referring physician

Below describes appropriate guidelines for consultations referred by primary care clinics:

Supplemental Authorization Consultations	
Cardiology	Oncology
Cardiovascular Surgery	Ophthalmology
Gastroenterology	Podiatry
Nephrology	Pulmonology
GYN	Surgery (other than hernia repair/lipoma)
Hematology	PT/OT/ST

Evaluations

An evaluation referral is an authorization for an evaluation and or treatment:

- Clinic completes the CMS Request for Referral Services (CMS-19) form found in Attachment B identifying the patient, the patient's dates of eligibility, the reason for the evaluation, the services authorized, the name of the primary care practitioner and the "valid to" date
- A brief history and any pertinent test results should accompany the CMS Request for Referral Services (CMS-19) form
- The form will indicate an evaluation and any additional tests or procedures that are authorized
- Please send your medical findings back to the referring primary care practitioner

Below describes appropriate guidelines for evaluations referred by primary care clinics:

CMS Request for Referral Services (CMS-19)	
Orthopedics	Retinology
Neurology	Optometry
Neurosurgery	General Surgery (hernia repair/lipoma)
Otolaryngology	Dermatology
Rheumatology	All UCSD services
Urology	Oral surgery

If a CMS patient presents him or herself to a specialist physician's office without an authorization, he or she should be referred back to their primary care clinic. If the CMS patient has received services for an inpatient stay or an emergency room visit and requires specialty care, please call a CMS Authorization Coordinator for further assistance at (858) 495-1300.

Treatment Authorization Requests (TAR)

When it is appropriate for the specialist physician to continue to follow the patient, the physician must submit a written plan of treatment (CMS Treatment Authorization Request form found in Attachment C) directly to the CMS Medical Management mailing address or FAX number below:

County Medical Services (CMS) Program
Patient Care Authorization
PO Box 939016
San Diego, CA 92193
Fax: (858) 495-1399

All non-clinic, non-emergency services provided to CMS patients must be prior approved.

Authorization from the ASO is required for:

- Ongoing specialty care
- CT scans and MRIs
- Outpatient hospital services such as nuclear studies, hyperbaric treatments, invasive procedures and outpatient surgery
- Scheduled admissions
- Special medical devices and supplies, orthotics and prosthetics, rehabilitation therapy and home health care
- Non-formulary drugs (prior authorization by the Pharmacy Benefits Manager, Pharmacy Care Network (PCN)

The CMS Treatment Authorization Request form found in Attachment C may be used when mailing or faxing the request.

- Patient name, date of birth, Social Security number and CMS eligibility period
- Specific services requested including treatment plan and planned procedures
- Medical findings which indicate the severity of the condition (i.e., copy of SOAP notes including signs and symptoms, history, and physical examination pertinent to the treatment requested, and, when indicated, diagnostic lab and x-ray reports)
- Location where the service will be provided (office, ancillary provider or name of facility)
- Anticipated length of stay for scheduled admissions
- Current CPT procedure codes

The authorization generally includes minor office procedures and routine laboratory and radiology studies. Please give the authorization number to outside lab or x-ray departments to assist them with their billing.

The ASO will send an approval notice to both the requesting physician and the ancillary vendor when the request has indicated that an allied service (rehab therapies, DME, outpatient hospital procedure, etc.) is part of the patient's plan of care.

All CMS authorizations are valid for a limited time. To ensure payment, the patient must be seen before the "valid to" date noted on the referral. Consults authorized by primary care are only valid sixty (60) days from the ordered date.

Urgent Requests

If the medical service requested is urgent, (i.e., it is medically necessary to provide services within seventy-two (72) hours), please call the Provider Line (858-495-1300) for verbal authorization. The CMS Authorization staff may ask the office staff to FAX applicable medical information. The specialist will also receive a Treatment Authorization Notification within five (5) to seven (7) business days.

Notifications

Approval

After the service is reviewed, the physician's office will receive notification of the outcome, usually within five (5) to seven (7) business days. The CMS Treatment Authorization Notification form (found in Attachment D) states the authorization number, the service(s) authorized and the effective dates of the authorization based on either the plan of care or the patient's eligibility dates.

- When the service cannot be provided before the expiration date, contact the ASO Provider Line to request an extension of the time period before providing the care. Repeated requests for retro authorization due to administrative oversight may result in denials. All claims submitted for services provided beyond the "valid to" date are rejected as outside of the approved period

Denial

Only the CMS Program Medical Director can deny a medical service as medically unnecessary or inappropriate. An example of the CMS Notice of Denial Request for Authorization (CMS-12) form is found in Attachment E.

Reconsideration and Appeal Process

The ordering physician may ask the Medical Director to reconsider the denial for a medical service. The patient is also notified that a service has been denied and is informed of his/her rights and the appeal process. Either party's request for reconsideration must be submitted in writing within thirty (30) days of the date of denial. Send to:

CMS Program
Attn: Medical Appeals
PO Box 939016
San Diego, CA 92193
Phone: (858) 492-4422
FAX: (858) 565-4091

The ASO Medical Management will review the case in depth and may contact the physician or other providers for additional information. The physician and the patient will be notified of the decision within forty-five (45) calendar days from receipt of the request for reconsideration or appeal. Expedited appeals may be requested for urgent requests within three (3) business days.

Section VII

Inpatient and Emergency Room Services

Emergency Admissions

CMS contracting hospitals must notify the ASO within twenty-four (24) hours (extended to the first day following a weekend or holiday) of any admission of a CMS (or potential CMS) patient. Requests for retroactive authorization of CMS (or potential CMS) patient admissions must be made within the ten (10) days of the admission date in order to be considered. The hospital stay shall be subject to retrospective medical review by the ASO, which may result in disallowance of all or some patient days.

The final status of the admission is based on the eligibility determination process, the diagnosis, and the patient's length of stay. The patient's application process may take several weeks to complete. The ASO generates authorization numbers only for certified patients. Inpatient authorizations are global and include facility, equipment and all technical and professional services for the hospital stay.

Scheduled Admissions

Scheduled, non-emergent admissions and outpatient surgical procedures must be prior authorized by submitting a Treatment Authorization Request or written request. The ASO sends written confirmation to both the ordering physician and the facility that indicates the approved procedure(s) and the valid dates for the service.

Post Discharge Care

- One (1) post discharge office visit to the physician is covered within thirty (30) days following an approved inpatient stay
- Diagnostic tests (lab, x-ray, EKG, etc.) require separate authorization
- Ancillary services such as durable medical equipment and home health require separate authorization

Emergency Room (ER) Services

Approved emergency services must meet the following conditions:

- The patient must show a valid CMS card or complete the CMS Emergency Department Episode Application
  - The ER and associated services are covered for CMS certified patients (CMS cardholders) at both contracted and non-contracted hospitals
  - The ER and associated services are covered for a patient with an approved ER Episode Application only at contracted hospitals
- The condition must be included in the CMS covered services (Section III, Page 1) and must be medically necessary **(ER visits for follow-up or prescriptions are not covered)**
- The place of service listed on the claim form must be the ER

Covered Emergency Room Services

- All facility, technical services and supplies provided during the emergency room episode are included in the hospital's reimbursement
- Emergency physician, specialty physician and ambulance services are claimed and paid separately and must have occurred during the approved ER episode
- DME that is given to the patient during or after the ER episode is paid separately only when authorized by CMS

Emergency Room Follow-Up

All patients must receive information about how to obtain follow-up care through the CMS Program when they are discharged from the ER. A sample of the CMS Application Packet (CMS-35, CMS-36, CMS-37) is found in Attachment F.

- Certified patients are encouraged to contact their primary care physician for continued care or referral
- Standard eligibility and prior authorization are required for additional services, including follow-up by a specialty physician
- The primary care clinics are notified quarterly of their patients' ER visits and are encouraged to contact patients for follow-up care with their primary care physician

Section VIII

Prescription Medications

The CMS Program covers prescriptions and pharmaceutical products listed in the CMS Drug Formulary Listing found in Attachment G. In addition to the list of covered pharmaceutical products, the introduction explains general coverage regulations and directions for obtaining authorization for non-formulary prescriptions.

Prescriptions

- CMS patients receive approved medications at no cost
- All prescriptions must be filled at participating pharmacies, listed in Attachment H. (All SAV-ON Pharmacies in San Diego County as well as independent pharmacies.)
- Patients may receive up to a maximum of a thirty (30) day supply of a prescribed drug. Code I drugs (restricted to a diagnosis or an amount that can be dispensed per month) are clearly marked in the formulary

Formulary Exclusions

Drugs and drug types excluded from the CMS Program Drug Formulary Listing are:

- Birth control products and medications for non-pathologic reasons
- Psychotropic and psychotherapeutic therapies prescribed only for mental health conditions
- Experimental drugs or drugs used in an experimental manner
- Non-formulary over-the-counter drugs, prescribed or not
- Nicotine and smoking cessation products
- Organ anti-rejection medications

Other Products

Contact a CMS Authorization Representative at (858) 495-1300 for authorization of durable medical equipment, wound supplies or nutritional supplements.

Prior Authorization Process

Requests for non-formulary medication require medical justification from the physician. When presented with a prescription for a non-formulary medication, the pharmacy may contact you to consider a formulary alternative.

To obtain authorization of a non-formulary medication, complete the CMS Drug Prior Authorization Request form (found in Attachment I) and fax the request to PCN, the CMS Pharmacy Benefit Manager:

Pharmacy Care Network (PCN)
(800) 945-1815

Urgent requests may be called to PCN at (800) 777-0074.

Contracting Facilities

A listing of primary care clinics, contracting hospitals and pharmacies can be found in Attachment H.

Section IX

Claims

Overview

The ASO Claims Department processes all claims submitted by hospitals, clinics, specialty physicians and ancillary providers seeking payment from the CMS Program.

Submission Requirements

All claims must:

- Be for services and service dates that match the certified patient's eligibility and period authorized
- Be submitted electronically or on the HCFA-1500 Form (Note: When the patient has other health coverage (OHC), you must submit a claim to the other insurance carrier first, and then attach the other carrier's EOB to the HCFA before submitting your claim to CMS)
- Include the following information:
  - Patient name, birth date, and Social Security Number
  - Date(s) of service
  - Place of service
  - Vendor and group name, address and phone number
  - Name and address of facility where services were rendered (if different from the billing office)
  - Medi-Cal Provider number
  - Provider Tax ID number
  - ICD-9 Codes
  - Current RVS, CPT, HCPCS, DRG and Medi-Cal codes as indicated
  - Authorization number (TAR control number)
  - Referring physician required
  - Full itemization of charges including drugs and supplies provided
  - All documentation and attachments required by Medi-Cal
  - Catalogue page or invoice when submitting an unlisted or "miscellaneous" code

- Be submitted within 30 (thirty) days from the date of services but no later than July 31 to:

AmeriChoice, ASO
County Medical Services (CMS) Program
Claims Department
PO Box 939016
San Diego, CA 92193

Checking Claim Status

The ASO processes claims that are complete and accurate within thirty (30) days of receipt. If you have not received payment within forty-five (45) days, you must call (858) 495-1333 to ask about the claim's status.

Reimbursement

Checks and the Remittance Advice (RA) are produced on twice a month basis. CMS reimbursement is considered payment in full.

You may not bill patients for:

- Any balance of fees or other associated costs after CMS pays for the service(s)
- Any administrative errors (incorrect coding, failure to obtain timely authorization or late submission)

You may bill patients for:

- Unauthorized services
- Services not covered in the CMS Program's medical criteria

Notification of Changes to Provider Information

To ensure that your check is accurate and timely, immediately notify ASO Claims Department at (858) 495-1333 of any changes in:

- Ownership
- Address (mailing and/or service site)
- Group affiliation
- Tax identification number (TIN)

Medi-Cal Pending or Approved

CMS covers necessary medical care for certified patients who are awaiting a Medi-Cal disability determination. Claims for these patients will be processed according to standard CMS claims processing procedures and the program recovers payments directly from Medi-Cal.

- CMS will pay for authorized services when a patient is pending a Medi-Cal determination
- All claims received after the CMS Program is notified that a patient is awarded Medi-Cal will be denied
- CMS will notify providers of the Medi-Cal eligibility on the RA
- Providers cannot bill Medi-Cal for services billed to or paid by CMS. In the event you receive payment from Medi-Cal for a service paid by CMS you must, within thirty (30) days from receipt of Medi-Cal payment, reimburse the CMS Program
- The Medi-Cal Program often requires prior authorization and medical documentation for specified procedures. CMS requires that you provide the necessary documentation upon request (medical records, Medi-Cal provider numbers) to facilitate revenue recovery for CMS
- Providers are to notify the CMS Program if they become aware a patient started receiving Medi-Cal

Appeal Process for Denied Claims

When you disagree with the level of payment or the denial of a claim, you must submit a written appeal within thirty (30) days of the denial notification. Clearly state the reason for the appeal and provide additional justification for payment. Send all documentation for the appeal to:

CMS Program - Appeals
Attention: Claims Department
PO Box 939016
San Diego, California 92193
FAX: (858) 495-1329

If you have questions, call the Claims Department at (858) 495-1333 for instructions about submitting your appeal. The ASO will review the claim and additional information and notify you of the decision within forty-five (45) calendar days.

Section X

Attachments